STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155651	A. BUILDING _____ B. WING _____	R 05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEVIEW CENTER OF FRANKLIN	651 S STATE ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 04-02-12.

Survey Dates: May 22, 23, & 24, 2012.

Facility Number: 000353
Provider Number: 155651
AIM Number: 100291330

Survey Team:
Patti Allen, BSW, TC
Marcy Smith, RN (May 22, 23, 2012)
Dinah Jones, RN

Census Bed Type:
SNF/NF: 107
SNF: 4
Total: 111

Census Payor Type:
Medicare: 9
Medicaid: 74
Other: 28
Total: 111

Sample: 10

Homeview Center of Franklin was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey.

Quality review completed on May 25, 2012 by Bev Faulkner, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE